

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-018908

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. **1**

Primary Registration District No. **3000**

Registrar's No. **187**

FILED MAY 27 1963

VS 300
Rev. 4/59

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DATE AMENDED

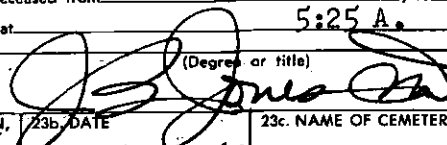
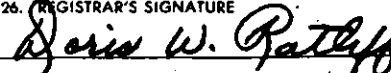
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Adair | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville | | Length of stay in 1b 1 day | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Grim-Smith Hospital & Clinic | | Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 3. NAME OF DECEASED (Type or print) First IDA Middle ESTELLA Last COONS | | 4. DATE OF DEATH Month May Day 20 Year 1963 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2-7-83 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9b. AGE (last birthday) 80 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (City and state or country) Knox County, Missouri | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13. FATHER'S NAME John W. Calef | |
| 14. MOTHER'S MAIDEN NAME Martha E. Cloyd | | 15. NAME OF HUSBAND OR WIFE Albert Lee Coons | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of war) Unknown | | 17. SOCIAL SECURITY NO. Unknown | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 36 hours | |
| DUE TO (b) Arteriosclerotic heart disease | | 5 years | |
| DUE TO (c) None | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour 5:25 A. Month, Day, Year 5-20-63 | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION Kirksville, Missouri | |
| 20g. COUNTY Adair | | 20h. STATE Mo. | |
| 21. I attended the deceased from 8-2-58 to 5-20-63 and last saw her alive on 5-19-63 Death occurred at 5:25 A. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE  | | 22b. ADDRESS Kirksville, Missouri | |
| 22c. DATE SIGNED 5-21-63 | | 22d. NAME OF CEMETERY OR CREMATORY Maple Hills Cemetery | |
| 22e. LOCATION (City, town, or county) Kirksville | | 22f. STATE Mo. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 22, 1963 | |
| 24. FUNERAL DIRECTOR Davis & Davis, Kirksville, Mo. | | 25. DATE RECD. BY LOCAL REG. May 24 1963 | |
| 26. REGISTRAR'S SIGNATURE  | | 27. DATE SIGNED May 24 1963 | |

USE BLACK INK
OR
TYPEWRITER RIBBON

The permit issued

J. B. JONES, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Robert B. Jones

Licensed Embalmer No. 4219

P. O. Address Kirksville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.